Presbyterian Insurance Company

Schedule of Benefits

CITY OF ALBUQUERQUE

MY CARE INDEPENDENT
(IIG10000)

The following Schedule of Benefits is a summary that describes the Copayment amounts that apply to specific types of services. Some benefits require Benefit Certification by Presbyterian Insurance Company (PIC). Benefits may have limits and certain services are excluded altogether. When the Copayment is expressed as a percentage, the percentage will be applied to the Total Allowable Charges for the particular procedure allowed by PIC. For a more complete description, please refer to Sections of the Subscriber Agreement that discuss How the Plan Works, General Information, Benefits, Benefit Certification, Limitations and Exclusions.

Underwritten by
Presbyterian Insurance Company, Inc.

PRESBYTERIAN

CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000) BENEFITS AND COVERAGE	LIMITS	
	In-Network	**Out-of-Network[3]**
ANNUAL CALENDAR YEAR DEDUCTIBLE – Does not apply to out of pocket maximum.	None	$500 per Individual Family: $1,500
ANNUAL OUT-OF-POCKET MAXIMUM	2x Annual Premium Does not include Deductible, Prescription Drug Copayments, charges over Reasonable and Customary or non-covered charges including charges incurred after the benefit maximum has been reached. PIC pays 100% of Covered charges after the out-of-pocket maximum has been met and up to Reasonable and Customary when applicable)	Individual: $6,000 Family: $18,000 Includes Co-insurance only – Does not include Deductible, Copayment, penalty amounts, charges above Reasonable and Customary, Prescription Drug Copayments, or non-covered charges including charges incurred after the benefit maximum has been reached. PIC pays 100% of Covered charges after the out-of-pocket maximum is met and up to Reasonable and Customary when applicable.
MAXIMUM LIFETIME BENEFIT	Unlimited	
MAXIMUM LIFETIME TRANSPLANT BENEFIT	$500,000 (Including Immunosuppressive drugs)	**Not Covered**
UNIQUE SERVICES PROGRAM – Refer to the Group Subscriber Agreement for more details.	$250 reimbursement per family per Contract Year for: • Prescription Drug costs – Copayments, Prescriptions not covered by the Prescription Drug benefits, delivery charges for home delivered prescriptions. • Routine vision care – Eye refraction's, glasses, contact lenses • Disease management classes • Alternative therapies – such as yoga, acupuncture, massage therapy, chiropractic, hypnotherapy and biofeedback above and beyond those services covered by the benefit portion of this plan • Hearing aids * If recommended by a Physician to treat a specific medical condition. A note or Prescription from the Provider and the Unique Services Reimbursement Form must be submitted.	
BENEFITS AND COVERAGE	**COPAYMENT**	
PHYSICIAN SERVICES including: • Non-Specialist • Specialist Home visits if Medically Necessary Outpatient Surgery (In Physician's office)	 $25 Copayment per visit $35 Copayment per visit $35 Copayment per visit Included in office visit Copayment	 40% 40% 40% 40%
Specialty Pharmaceuticals[1] (Injectable forms administered in Physician's office)	$50 per injection	**Not Covered**

PHYSICIAN SERVICES *continued on next page*

[1] Benefit Certification may be required [2] Not subject to Deductible [3]Benefits are limited to Reasonable and Customary Charges. You are responsible for any balance due above Reasonable and Customary Charges. [4] 15% penalty applies if Benefit Certification is not obtained.

Refer to the Group Subscriber Agreement for a more complete description of benefits

CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000) BENEFITS AND COVERAGE	In-Network	Out-of-Network
PHYSICIAN SERVICES *continued*		
Allergy Services		
• Testing	20% Copayment	40%
• Serum (extracts)	20% Copayment	40%
• Injections	Included in office visit Copayment (waived if nursing visit only)	40%
Injections such as insulin, heparin and injectable antibiotics	Included in office visit Copayment (waived if nursing visit only)	40%
Infertility Services including drugs and injections[1]	50% Copayment	**Not Covered**
On-campus Student Health Center	$25 Copayment per visit	$25 Copayment per visit
Hospital and Skilled Nursing Care visits	$0 Copayment	40%
HOSPITAL SERVICES – Inpatient[1] Coverage Includes: • Room and Board • Newborn delivery and other Hospital Obstetrical services • In-Hospital Physician visits, Surgeons, Anesthesiologist and other Inpatient Services • Detoxification	$150 Copayment per day up to a maximum of $450 per admission	40% [4]
MEDICAL SERVICES – Outpatient		
• Surgeries[1] (at facility)	$125 Copayment per visit	40%[4]
• X-ray and laboratory tests	$0 Copayment	40%
• PET[1]/MRI Scans	$125 per test	40% [4]
• Cardiac Cath	$200 Copayment per visit	40%
• GI Lab	$175 per visit	40%
• CAT Scan	$75 per test	40%
• Radiation Therapy (Non-surgical)	$0 Copayment	40%
• Chemotherapy	$0 Copayment	40%
• Specialty Pharmaceuticals[1] – Oral or inhalation forms/Self-administered, Intravenous (IV)	$50 per prescription	**Not Covered**
• Specialty Pharmaceuticals[1] – Intravenous (IV)	$0 Copayment	**Not Covered**
• Sleep Studies	$50 Copayment per study	40%
• Administration of blood/blood components	$0 Copayment	40%
RECONSTRUCTIVE SURGERY[1]	Included in Hospital Services – Inpatient, Medical Services – Outpatient, and Physician Services	40% [4]

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CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000) BENEFITS AND COVERAGE	In-Network	Out-of-Network
EMERGENCY ROOM CARE Including trauma services	$75 Copayment per visit (waived if admitted into a Hospital, then Hospital Copayment applies)	$75 Copayment per visit[2] (waived if admitted into a Hospital, then Hospital Copayment applies)
URGENT CARE		
• Participating Provider/Practitioner	$35 Copayment per visit	NA
• Non-Participating Provider/Practitioner (In or out of the Service Area)	NA	$45 Copayment per visit [2]
AMBULANCE SERVICES including:		
Emergency or high-risk		
• Ground ambulance	$50 Copayment per occurrence	$50 Copayment per occurrence
• Air ambulance	$100 Copayment per occurrence	$100 Copayment per occurrence
Inter-Facility transfer services		
• Ground ambulance	$0 Copayment	$0 Copayment
• Air ambulance	$100 Copayment per occurrence	$100 Copayment per occurrence
CLINICAL PREVENTIVE SERVICES		
Well Child Care including vision and hearing screening	$15 Copayment per visit	40%[2]
Preventive physical exam	$15 Copayment per visit	40%[2]
Adult and child immunizations	Included in office visit Copayment (waived if nursing visit only)	40%[2]
Office Based Health education	Included in office visit Copayment	40%[2]
Family planning services	Included in office visit Copayment	40%[2]
Cytologic Screening (Pap Smear)	Included in office visit Copayment	40%[2]
Mammography	Included in office visit Copayment	40%[2]
Human Papillomavirus (HPV) Screening	Included in office visit Copayment	40%[2]
Health Education	Included in office visit Copayment	40%[2]
WOMEN'S HEALTH CARE		
Gynecological Care	$25 Copayment per visit	40%
In office Obstetrical/Maternity Care/Prenatal & Postnatal care	$25 Copayment per visit up to a maximum of $250 per pregnancy	40%
Specialist (i.e. Perinatologist)	$35 Copayment per visit not included in $250 maximum listed above	40%
Cytologic (Pap Smear), Human Papillomavirus (HPV) screening, and Mammograms refer to Clinical Preventive Services.		
Newborn Delivery and other Hospital Obstetrical Services	$150 per day up to a maximum of $450 Copayment per admission	40%
Implantable contraceptive devices		
• Insertion	50% Copayment per insertion	50%
• Removal	Included in office visit copayment	40%

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Refer to the Group Subscriber Agreement for a more complete description of benefits

CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000) BENEFITS AND COVERAGE	In-Network	Out-of-Network
DIABETES SERVICES		
Office visit and Diabetes education	Included in office visit Copayment	40%
Diabetic supplies[1] (Purchased through a Participating Durable Medical Equipment Supplier)	50% Copayment	50%[4]
Diabetic supplies including Insulin and diabetic oral agents for controlling blood sugar (Purchased through a Participating Pharmacy)	Generic (Preferred) – $10 Copayment Brand (Preferred) – $30 Copayment Non-Preferred – $50 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
COVERED MEDICATIONS – Outpatient (Purchased at a Participating Pharmacy, unless due to an emergency occurring outside of the PIC Service Area)		
• Medically Necessary Nutritional Supplements for prenatal care • Insulin and diabetic oral agents • Diabetic supplies (purchased through a Participating Pharmacy) • Smoking cessation drugs (Limited to two (2) 90-day courses of treatment per Calendar Year)	Generic (Preferred) – $10 Copayment Brand (Preferred) – $30 Copayment Non-Preferred – $50 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
Immunosuppressive drugs following transplant surgery (Subject to lifetime transplant maximum)		
• Oral	Generic (Preferred) – $10 Copayment Brand (Preferred) – $30 Copayment Non-Preferred – $50 Copayment (Per 30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Injectable	$0 Copayment per injection	**Not Covered**
Specialty Pharmaceuticals[1] - Oral or inhalation forms/Self-administered	$50 per prescription	**Not Covered**
Specialty Pharmaceuticals[1] - Intravenous (IV)	$0 Copayment	**Not Covered**
Special Medical Foods[1]	50% Copayment	**Not Covered**

This plan is considered Creditable per Medicare part D guidelines. For more information regarding Medicare Part D please refer to www.cms.gov.

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Refer to the Group Subscriber Agreement for a more complete description of benefits

CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000) BENEFITS AND COVERAGE	In-Network	Out-of-Network
PRESCRIPTION DRUGS (RETAIL)		
• Generic (Preferred)	$10 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Brand (Preferred)	$30 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Brand (when a generic equivalent is available)	Generic Copayment plus the difference in the cost of the brand and generic per (30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Non-Preferred	$50 Copayment (30-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Pre-packaged items	Applicable Copayment (generic, brand, Non-Preferred) per pre-packaged item	**Not Covered**
PRESCRIPTION DRUGS (MAIL ORDER)		
• Generic (Preferred)	Applicable Copayment (generic, brand, Non-Preferred) per pre-packaged item	**Not Covered**
• Brand (Preferred)	2 x generic Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Brand (when a generic equivalent is available)	2.5 x brand Copayment (90-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Non-Preferred	2 x generic Copayment plus the difference in the cost of the brand and generic (90-day supply up to the maximum dosing recommended by the manufacturer)	**Not Covered**
• Pre-packaged items	3 x Non-Preferred Copayment (90-day supply up to the maximum dosing recommended by the manufacturer) Applicable mail order Copayment (generic, brand, Non-Preferred) per pre-packaged item	**Not Covered**
MENTAL HEALTH SERVICES[1]		
Outpatient	$35 Copayment per visit	40%
Inpatient	$150 per day up to a maximum of $450 Copayment per admission	40%[4]
Partial Hospitalization	$150 per day up to a maximum of $450 Copayment per admission (waived if immediately following an Inpatient hospitalization discharge)	40%[4]

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CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000) BENEFITS AND COVERAGE	In-Network	Out-of-Network
ALCOHOL AND SUBSTANCE ABUSE SERVICES[1]		
Detoxification		
• Outpatient	$35 Copayment per visit	40%[4]
• Inpatient	$150 per day up to a maximum of $450 per admission	40%[4]
Rehabilitation		
Outpatient - up to 20 visits per Calendar Year	$35 Copayment per visit	40%[4]
Inpatient or partial hospitalization - up to 30 days per Calendar Year	25% Copayment per admission	40%[4]
Combined Inpatient and Outpatient services are limited to one episode of treatment per Calendar Year, three episodes per lifetime.		
REHABILITATION AND THERAPY SERVICES		
Cardiac Rehabilitation (up to 12 sessions continuous ECG monitoring and 24 sessions intermittent ECG monitoring per Calendar Year)	$25 Copayment per session	**Not Covered**
Dialysis/Plasmapheresis/ Photophoresis	20% Copayment per visit	40%
Pulmonary Rehabilitation (up to 24 sessions per Calendar Year)	$25 Copayment per session	**Not Covered**
Short-term Rehabilitation[1] (Physical and Occupational Therapy up to 2 months per condition)		
• Inpatient	$150 per day up to a maximum of $450 Copayment per admission (waived if transferred directly from an Inpatient Hospital, Hospice, or Skilled Nursing Facility)	40%[4]
• Outpatient	$35 Copayment per session	40%[4]
Speech and Hearing Therapy* (up to 2 months per condition)	$35 Copayment per session	**Not Covered**
TRANSPLANTS[1] Subject to lifetime transplant maximum	$150 per day up to a maximum of $450 Copayment per admission	**Not Covered**

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CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000) BENEFITS AND COVERAGE	In-Network	Out-of-Network
COMPLEMENTARY THERAPIES (Limited)		
Acupuncture Services (up to 20 visits per Calendar Year if Medically Necessary as specified in Section IV.F of the Group Subscriber Agreement)	$35 Copayment per session	40%
Chiropractic Services (up to 18 visits per Calendar Year if Medically Necessary)	$35 Copayment per session	40%
Biofeedback for specific conditions	$25 Copayment per session	40%
SKILLED NURSING FACILITY[(1)] (Up to 60 days per Calendar Year)	$150 per day up to a maximum of $450 Copayment per admission (waived if transferred directly from an Inpatient Hospital, rehabilitation, or Hospice facility)	40%[(4)]
HOME HEALTH CARE SERVICES[(1)]/ HOME INTRAVENOUS SERVICES[(1)]		
Services provided by an RN, LPN and other specified specialist	$0 Copayment	40%[(4)]
Home intravenous services and supplies	$0 Copayment	40%[(4)]
Specialty Pharmaceuticals[(1)] - Oral or inhalation forms/Self-administered	$50 per prescription	**Not Covered**
Specialty Pharmaceuticals[(1)] - Intravenous (IV)	$0 Copayment	**Not Covered**
HOSPICE CARE[(1)]		
Inpatient	$150 per day up to a maximum of $450 per admission (waived if transferred directly from an Inpatient Hospital, rehabilitation, or Skilled Nursing Facility)	40%[4)]
In-home	$0 Copayment	40%[4)]
DURABLE MEDICAL EQUIPMENT, PROSTHETICS, AND APPLIANCES[(1)]	50% Copayment	50% Copayment[(4)]

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CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000) BENEFITS AND COVERAGE	In-Network	Out-of-Network
EYEGLASSES AND CONTACT LENSES[1] Limited to the following: • Eyeglasses and contact lenses within 12 months following cataract surgery or for the correction of keratoconus, or when related to Genetic Inborn Errors of Metabolism • Refraction eye exam associated with post cataract surgery or keratoconus correction	50% Copayment Included in office visit Copayment	**Not Covered** **Not Covered**
DENTAL SERVICES/(CMJ/TMJ) (Limited)	Included in office visit Copayment	40%
FAMILY, INFANT AND TODDLER PROGRAM **Family, Infant and Toddler Program (FIT):** Medically Necessary early intervention services provided as part of an individualized family service plan and delivered by certified and licensed personnel as defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services.	No Copayment $3,500 per Member per Calendar Year Maximum benefit Not applicable to any lifetime maximums or annual limits	

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Refer to the Group Subscriber Agreement for a more complete description of benefits

EXCLUSIONS CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000):

Refer to the Group Subscriber Agreement for a more complete description of Exclusions & Limitations.

Any exclusion listed would not be applicable if covered under the FIT Program in accordance with that which is defined in NMAC Title 7, Chapter 30, Part 8 Health Family & Children Health Care Services. Refer to your Group Subscriber Agreement for details.

- **Alternative/complementary therapies,** except as specified in the Group Subscriber Agreement (GSA) and as provided for under the Unique Service Reimbursement Program.
- **Any service**, treatment, procedure, facility, equipment, drugs, drug usage, device or supply determined to be **not Medically Necessary** or accepted medical practice.
- **Artificial aids** including speech synthesis devices except items identified in the Group Subscriber Agreement (GSA).
- **Athletic trainers**.
- **Autopsies** and/or transportation costs for deceased Members.
- **Baby food** (including baby formula or breast milk) or other regular grocery products that can be blenderized for oral or tube feedings.
- **Benefits and services not specified as Covered.**
- **Biofeedback**, except as specified in the Group Subscriber Agreement (GSA) and as provided for under the Unique Service Reimbursement Program.
- **Cancer Clinical Trials** are limited to phase 2, 3 and 4 and must be provided for in the State of New Mexico in **accordance with the provisions set forth in the Group Subscriber Agreement (GSA).**
- **Care for conditions which State or local law requires** be treated in a public or correctional facility.
- **Care for military service connected disabilities** to which the Member is legally entitled and for which facilities are reasonably available to the Member.
- **Charges that are determined to be unreasonable by PIC.**
- **Circumcisions** performed other than during the newborn's Hospital stay unless Medically Necessary.
- **Clothing** or other protective devices including prescribed photoprotective clothing, windshield tinting, lighting fixtures and/or shields, and other items or devices whether by prescription or not.
- **Co-dependency** treatment.
- **Convenience items.**
- **Cosmetic surgery, treatments**, devices, orthotics, and medications, including treatment of hair-loss.
- **Costs for extended warranties** and premiums for other insurance coverage except as provided for under the Unique Service Reimbursement Program.
- **Counseling –** sex, pastoral/spiritual, and bereavement counseling.
- **Court ordered evaluation or treatment**, or treatment that is a condition of parole or probation or in lieu of sentencing, such as Alcohol or Substance Abuse programs and/or psychiatric evaluation or therapy.
- **Covered services obtained from a Non-Participating Provider/Practitioner**, except as provided in the Group Subscriber Agreement (GSA) and as provided for under the Unique Services Reimbursement Program.
- **Custodial or domiciliary care** except as provided for under the Unique Service Reimbursement Program.
- **Dental care** and dental x-rays, except as provided in the Group Subscriber Agreement (GSA) and as provided for under the Unique Services Reimbursement Program.
- **Dental implants** except as provided for under the Unique Services Reimbursement Program.
- **Disposable medical supplies**, except when provided in a Hospital or a Physician's office or by a home health professional.
- **Donor Sperm.**
- **Durable Medical Equipment/Prosthetics/Orthotics** as listed as Covered in this Schedule of Benefits and the Group Subscriber Agreement – additional wheelchairs, duplicate items, convenience items, upgraded or deluxe items, repair or replacement due to loss, neglect, misuse, abuse, to improve appearance, for convenience or items under the manufacturer or supplier's warranty.
- **Elastic support hose.**
- **Elective abortions** after the 24th week of pregnancy.
- **Elective Home Birth** and any prenatal or postpartum services connected with an Elective Home Birth.
- **Emergency facility** used for non-emergent services.
- **Exercise equipment** and videos, personal trainers, club memberships and weight reduction programs.

EXCLUSIONS CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000):

- **Experimental/Investigational,** as determined by PIC, drugs medicines, treatments or procedures.
- **Extracorporeal shock wave therapy** involving the musculoskeletal system.
- **Eye movement therapy.**
- **Eye refractive procedures** including radial keratotomy, laser procedures, and other techniques except as provided for under the Unique Services Reimbursement Program.
- **Eyeglasses (Corrective)** or sunglasses, frames, lens prescription, contact lenses or the fitting thereof except as provided in the Group Subscriber Agreement (GSA) and as provided for under the Unique Services Reimbursement Program.
- **Foot care (routine)**, except as provided in the Group Subscriber Agreement (GSA).
- **"Get acquainted" visits** without physical assessment or diagnostic or therapeutic intervention provided.
- **Gloves,** unless part of a wound treatment kit.
- **Hair-loss** (or baldness) treatments, medications, supplies and devices including wigs, and special brushes.
- **Halfway houses.**
- **Hearing aids** and the evaluation for the fitting of hearing aids except as provided for under the Unique Service Reimbursement Program..
- **Home Sleep Studies.**
- **Home visits by a Physician.**
- **Hospice benefits are not available for the following services:** food, housing and delivered meals, volunteer services, comfort items such as, but not limited to, aromatherapy, clothing, pillows, special chairs, pet therapy, fans, humidifiers, and special beds (excluding those Covered under Durable Medical Equipment benefits), homemaker and housekeeping services, private duty nursing, pastoral and spiritual counseling or bereavement counseling.
- **Hypnotherapy** except as part of anesthesia preparation or chronic pain management and as provided for under the Unique Services Reimbursement Program.
- **Infant formula.**
- **In-vitro, GIFT and ZIFT fertilization.**
- **Lay midwife** – Services of a lay midwife or an unlicensed midwife.
- **Malocclusion treatment**, if part of routine dental care and orthodontics.
- **Massage Therapy**, unless performed by a licensed physical therapist and as part of a prescribed short-term physical therapy program and as provided for under the Unique Service Reimbursement Program.
- **Medical and Hospital services of a donor** when the recipient of an Organ transplant is a not a Member or when the transplant procedure is not covered.
- **New medications** for which the determination of criteria for Coverage has not yet been established by PIC's Pharmacy and Therapeutics Committee except as provided for under the Unique Service Reimbursement Program.
- **Nutritional supplements** except as provided in the Group Subscriber Agreement (GSA) and as provided for under the Unique Services Reimbursement Program.
- **Organ transplants not listed as Covered and Non-human organs,** except for porcine (pig) heart valve.
- **Orthodontic appliances, endodontics, dental prosthetics, crowns, bridges, and dentures** except as provided for under the Unique Services Reimbursement Program.
- **Orthodontic appliances** and orthodontic treatment, crowns, bridges, and dentures used for the treatment of Craniomandibular and Temporomandibular Joint disorders, unless the disorder is trauma related and as provided for under the Unique Services Reimbursement Program.
- **Orthopedic or corrective shoes**, arch supports, shoe appliances, foot orthotics, and custom fitted braces or splints except for patients with diabetes or other significant peripheral neuropathies.
- **Orthotics (functional foot)** except as provided in the Group Subscriber Agreement (GSA) for patients with diabetes or other significant neuropathies.
- **Orthotics/orthosis (Custom Fabricated)** except as specified in the Groups Subscriber Agreement (GSA).
- **Out-of-Network services** for Organ Transplants, Infertility services, Cardiac and Pulmonary rehabilitiation, covered medications, prescription drugs, Specialty Pharmaceuticals, and Special Medical Foods, except as provided for under the Unique Service Reimbursement Program.
- **Over-The-Counter (OTC) medications** except as specified in the Group Subscriber Agreement (GSA).
- **Personal or comfort items, services or treatments.**

EXCLUSIONS CITY OF ALBUQUERQUE MY CARE INDEPENDENT (IIG10000):

- **Photophoresis** for all conditions other than mycosis fungoides. **Physical examinations**, vaccinations, drugs and immunizations for the primary intent of medical research or non-Medically Necessary purpose(s) such as, but not limited to, licensing, certification, employment, insurance, flight, travel, passports or functional capacity examinations related to employment.
- **Prescription Drugs** (as listed as Covered in this Schedule of Benefits, and the Group Subscriber Agreement) received upon Hospital discharge, provided by a Hospital pharmacy unless a Participating outpatient pharmacy is not available except as provided for under the Unique Service Reimbursement Program.
- **Prescription Drugs requiring a Benefit Certification when Benefit Certification was not obtained** except as provided for under the Unique Service Reimbursement Program.
- **Prescription Drugs ordered by a Non-Participating Provider** or purchased at a Non-Participating Pharmacy unless required due to an emergency occurring outside of the Service Area and as provided for under the Unique Service Reimbursement Program.
- **Prescription Drug,** compounded medications except as provided for under the Unique Service Reimbursement Program.
- **Prescription Drug replacements** due to loss, theft, or destruction except as provided for under the Unique Service Reimbursement Program.
- **Private duty nursing.**
- **Psychological testing** when not Medically Necessary.
- **Residential Treatment Centers** unless for the treatment of Alcoholism and/or Substance Abuse rehabilitation.
- **Reversals of voluntary sterilization.**
- **Services for which the Member is eligible under any governmental program** (except Medicaid), or services for which, in the absence of any health service plan or insurance plan, no charge would be made to the Member or Dependent.
- **Services requiring Benefits Certification** when Benefit Certification was not obtained.
- **Sex transformation surgery and drugs** relating to sex transformation.
- **Sexual dysfunction treatment**, including medication, counseling, and clinics, except for penile prosthesis as provided in the Group Subscriber Agreement (GSA).
- **Special education**, school testing or evaluations, counseling, therapy or care for learning deficiencies or disciplinary problems. This applies whether or not associated with manifest mental illness or other disturbances. Except as provided for under the Family, Infant and Toddler (FIT) Program. Refer to the Group Subscriber Agreement (GSA) for more information.
- **Special Medical Foods,** except as listed as Covered in the Group Subscriber Agreement (GSA) for Genetic Inborn Errors of Metabolism.
- **Storage or banking** of sperm, ova (human eggs), embryos, zygotes, or other human tissue.
- **"Telephone visits** and electronic mail (E-mail)" by a Physician or "environmental intervention" or "consultation" by telephone for which a charge is made to the patient.
- **Transportation costs** for deceased Members.
- **Travel and lodging** expense, except as provided in the Group Subscriber Agreement (GSA).
- **Vision care (routine) and Eye Refractions** for determining prescriptions for corrective lenses, except as listed as Covered in the Group Subscriber Agreement (GSA) and as provided for under the Unique Services Reimbursement Program.
- **Visual training.**
- **Vocational Rehabilitation services and Long-Term Rehabilitation services.**
- **Weight reduction or control treatments**, except for Medically Necessary treatment for morbid obesity.
- **Work-related accidents** or injuries or occupational illness or disease if the Member is required to be covered under workers' compensation insurance, whether or not such coverage actually exists.

Refer to the Group Subscriber Agreement for a more complete description of Exclusions & Limitations.

Plan ID's - IIG10000

PRESBYTERIAN

This schedule of benefits and services is subject to the provisions of the contract and cannot modify or affect the Subscriber Agreement in any way; nor shall you accrue rights because of any statement in or omission from this schedule.

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